A PROGRAMME OF CARE FOR THE ELDERLY

by

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WITH the reorganisation of the various elements of the National Health Service under the Health and Personal Social Services (N.I.) Order (1972) there emerged in the succeeding structures the concept of programmes of care which was to deal with all aspects of the delivery of medical care. In Ballymoney, a small market town of 6,000 people, in the centre of a large agricultural area, there were various institutions and services provided for the care of the elderly but administered by different bodies. These have all now become the responsibility of the Northern Area Health and Social Services Board, and are administered by the District Team which consists of the District Administrative Medical Officer, District Administrative Officer, District Administrative Nursing Officer, District Social Services Officer and the Chairman of the District Medical Advisory Committee. Under this single unit of administration all the elements have been brought together, and a comprehensive programme of care for the elderly is now in operation.

Elements of Comprehensive Programme of Care for the Elderly

(1) *Family Practice*

This is in two parts, curative and preventive. There are two practices which are based in a comprehensive health centre (Burns, 1971) and which have a combined list of 11,872 patients. The practices are organised into two teams consisting of the family doctors, health visitors, district nurses and a social worker. The practice teams look after the elderly when they fall ill in their homes, and in this paper it will be shown that 93.19 per cent of all the patients over 65 years are cared for by this service. The family doctor also has on his visiting list the "chronics" who are analogous with the long stay patient in the hospital setting and need regular visiting even though not acutely ill; they number 157 or 15.05 per cent of the practice geriatric population.

Preventive geriatric care was established following the results of a study by Burns (1969) in which all patients when they reach 65 years of age are screened both medically and socially by the health visitors and any abnormality found is reported to the appropriate doctor. After the initial screening the practice of selective health visiting is used and thereby the geriatric population is under continuous review. This scheme has not usually found serious disease as Sheldon (1948), Hobson and Pemberton (1955), Anderson (1967), Irwin (1971) and others found, but it does discover a great number of degenerative conditions where help can be given and the process slowed down; and where social defects can be remedied and welfare aids provided. This has given a new dimension to Health Visiting and does not increase the work load unduly.

Table I gives a five year review.

TABLE I

Annual Geriatric Review 1969–73

	1969	1970	1971	1972	1973
Normal	12	33	58	52	32
Abnormal	16	25	18	21	39
Refused to co-operate	0	0	10	21	10
Total	28	58	86	94	81

(2) *Hospital Practice*

(i) *Robinson Cottage Hospital* (Acute, Short Stay Patients)

This is a small cottage hospital of 35 beds, of which 12 form a general practitioner obstetric unit. The remainder are controlled mainly by the general pracitioners, who use some of the beds for two categories of geriatric patient—(a) those suffering from acute illnesses and who are not likely to become "long stay patients", and (b) patients who are living with their families, and whose family wish to go for a two week holiday.

(ii) *Route Hospital* (Long Stay Patients)

The Route Hospital is a general hospital of 135 beds. The medical department admits long stay patients, but, like all other medical units, has to strive to preserve its acute medical beds. This is the dilemma which is common to all consultant physicians. To expect a consultant physician to have an enthusiastic medical interest in these patients is asking him to do something that he was not trained to do. Equally, it is wrong to expect the highly trained nursing staff to have this continuing interest. This is one of the most difficult areas of geriatric care, because when the crisis arises for the general practitioner and the family pressures have become unbearable, there is a natural resistance from the hospital staff to find a bed, and this produces friction between all branches of the health service. These frail old people who are called long stay patients do not need the highly developed skills of the consultant physician and nursing staff, but could be looked after and cared for equally well if they were taken out of the hospital setting and taken over by the social services section. This could be achieved if they were placed in a simple building and supervised by three (or multiples of three) nursing staff and a requisite number of welfare attendants; a general practitioner, with an interest in geriatric medicine, could be appointed on a sessional basis to give medical cover. The nursing staff would be able to give nursing advice and supervision, and call for medical help when required. This proposal would be infinitely less expensive than the present method, and, above all, it would remove all the emotional strains between the different branches of the profession to the great comfort of these old people, who would be given a renewed dignity.

(iii) *Acute Geriatric Unit* (Braid Valley Hospital, Ballymena)

This is a large geriatric unit of 190 beds situated at Ballymena, 18 miles away, with a consultant geriatrician. Patients from the Ballymoney area are sent here if

their condition is such that there is a reasonable hope of rehabilitation and recovery. These requests from the general practitioner are screened by the consultant geriatrician during a domiciliary visit; the object of this is to prevent long stay patients being admitted to active beds. Again, if the long stay patients were under the social services section, as suggested, this would free more beds for active rehabilitation and make the potential of the geriatrician and his unit so much greater.

(3) *Social Services*

(i) *The Roddens Welfare Home.* This is a recently built welfare home (Burns 1972) and it has accommodation for 44 residents. This home was built on a trunk route, is near to the library, shops and pubs. It is the experience of the home, which was opened in 1971 with a fairly active population, that this population has now become frail and that some are in the long stay hospital category. The average age is now 81.68 years with an age span of 68–90 years. It is staffed by a matron, assistant matron, nurse and twelve attendants, and a visiting medical officer (a general practitioner).

(ii) *Abbeyfield Home.* Some years ago a local Abbeyfield Society was formed and the Society asked the then Northern Ireland Housing Trust who were planning a housing estate if they would build an Abbeyfield Home. This they readily did, and it consists of six bed-sitters and is part of the estate overlooking a green common, near the library and near a busy thoroughfare. It has a common sitting-room and dining-room. The residents furnish their own rooms, and then keep them clean and tidy, and pay a weekly all-in rent. The key to the success and happiness of the home is the housekeeper.

(iii) *Evergreen Club.* This is a social club which meets weekly in the Social Centre, which was built ten years ago by partial Government grant and money raised locally. The club itself was started in 1949 and it caters for all people over 65 years of age, and residents from the welfare home mix with the local people, and people from the surrounding countryside who are brought in by two coaches which were generously donated. This is a very successful and cheerful side to local geriatric care.

(i) *Luncheon Club and Meals-on-Wheels.* This service was started by first setting up a local Community Committee and this Committee organises both the luncheon club and the meals-on-wheels. The local ladies and one man organised themselves on a rota basis and the club meets in the Social Centre.

(v) *Day Centre.* Work should be starting on this very vital part of caring for the elderly in 1975.

(vi) *Sheltered Housing.* In nearly all the housing estates there are small dwellings for old people, thus these old people are part of the community of the estate and are supported by the other residents. Health visitors, district nurses and social workers also call regularly, and the members of the practice team know where these old people live from the age/sex register.

(vii) *School Children Adoption.* The senior pupils of all the local schools are encouraged to adopt an old person and develop a relationship whereby they visit

them, read to them and do errands for them. This sort of "service" can be used by children working for the Queen's Guide Award, Queen's Scout Award and the Duke of Edinburgh Award. Some children take the old people out for motor car drives and into their homes.

(viii) *Pre-Retirement Lectures.* With the increasing number of very active and healthy people reaching the age of 65 it is very important and necessary that some help should be given to prepare them for retirement. People should begin to think and plan retirement about 5—7 years beforehand. With this in view the author organised a course of pre-retirement lectures which were delivered weekly in the Lecture Hall of the Ballymoney Health Centre. The topics were wide and varied and were as follows: —'Keeping physically fit' by the author; 'Keeping mentally fit' by the visiting psychiatrist; 'What your technical college can offer' by the principal; 'What your local library can offer' by the then county librarian; 'Budgeting on a lower income' by a retired bank manager; 'What benefits' by the manager of the local labour exchange; 'Eat well—keep well' by the health education officer; 'Safety in the home' by the Northern Ireland home safety officer; 'Social problems' by a social worker; 'Geriatric screening' by the health visitors, and 'The Evergreen Club' by the chairman of the club. In this small community it is hoped to repeat these lectures every three years.

Apart from having the various institutions, the success of the plan is dependent on good communications and good relationships between the many elements. This is achieved by having the structure of the general practitioner team which meets every day for consultation and discussion and each member of the team has a relationship with some elements of the plan. It is only on rare occasions that the plan does not work at local level, when the District Team have to be consulted to help solve some problem.

One Day Audit

In order to establish how well this programme of care for the elderly was used and what was the daily demand of this group of patients a one-day audit of the author's practice was carried out. The practice consists of 8,742 patients of which 1,043 were over the age of 65 years, giving a percentage of 11.9 per cent. This is lower than the prevailing, provincial and national figure. The following statistics show how many were being treated and taken care of on one day (24th October, 1974).

Route Hospital:	Medical	Total 11	4 Acute	7 Long Stay
	Surgical	Total 3	3 Acute	0 Long Stay
	Gynaecology	None		
	Outpatients	Total 2 (surgical)		
	X-Ray Dept.	1 Referred by G.P.		
Robinson Cottage Hospital		Total 6	5 Acute	1 Long Stay
Holywell Hospital		Total 0		
Braid Valley Hospital		Total 1		
Abbeyfield Home		Total 4		
Residential Accommodation:		Total 43—Roddens 38: Brookgreen 1 Runkerry 1: Metropole 3		

Health Centre:	Surgery Attendances 9: Treatment Room 10: Chiropody 8
General Practitioners' Visits:	Acute cases 7:
Health Visitors:	Acute cases 8:
District Nurses:	27 cases visited on 24/10/74
Luncheon Club:	6
Meals-on-Wheels:	23
Home Helps:	40

This information is summarised in Table II

TABLE II

Route Hospital	17	Health Visitors	8
Robinson Hospital	6	District Nurses	27
Braid Valley	1	Luncheon Club	6
Holywell Hospital	0	Meals-on-Wheels	23
Abbeyfield Home	4	Home Helps	40
Welfare Homes	43		
Family Doctors	16		
Treatment Room	10	TOTAL	209
Chiropody	8		

This means that on 24th October, 1974, 209 people out of 1,043 (20.03 per cent) were being cared for by all the branches of the National Health Service. Table III gives the percentage breakdown for each element of service to these 209 patients.

TABLE III

	Patients	*Percentage*
Family Practice	61	29.13
Hospitals	24	11.48
Residential Accommodation	47	22.48
Community Services	77	36.84

DISCUSSION

In 1901 there were about 1,500,000 people over 65 in Great Britain. In 1966 the figure was over 6,000,000 or 12 per cent of the population, and in 1974 it had risen to over 16 per cent and by 1990 it is estimated that there will be 10,000,000 (Harte, 1972). This, in statistical terms, is the extent of the problem of caring for the elderly that confronts the country today and till the end of this century. Therefore, it is very important that attempts should be made to plan for the needs of this increasing group of the population. The first priority is to prepare people for retirement and old age. Most people put off thinking about retirement, or else they look forward to it and the leisure hours that it brings, only to be quickly disillusioned by boredom and a feeling of not being wanted. This problem can be met

by education and this can be given in the form of a series of lectures. The next objective should be to keep the newly retired people healthy and active for as long as possible. This has been done in Ballymoney by setting up geriatric registers in the two practices, and by screening all the newly retired people. If there is an abnormality detected then action can be taken to correct it, or, at least slow down the process of degeneration. The health visitors, who do this work, then keep these people under supervision depending on the need, using the principle of selective health visiting. The day centre, Evergreen Club, luncheon club, meals-on-wheels, home helps, school children adoption scheme, all help to support and keep the elderly at home.

It should be the accepted principle that old people are best cared for, and are happier, in their home environment, and vigorous steps should be taken to try and keep them there. This has been achieved in large measure in Ballymoney, there being only eight long stay patients from the author's practice on the 24th October 1974.

By using this scheme of preventive geriatric care 93.19 per cent of the patients of this group in the practice were living at home, and because such a great number are at home the daily work load is considerable; that is, on 24th October 1974, 209 patients (20.03 per cent) were being cared for by members of the practice team or the community services.

When the small number 71 (6.80 per cent) can no longer be accommodated at home, they will either have to go to hospital or into residential accommodation. With good supervision by the practice team this change in status can be anticipated and, therefore, their removal can be planned, but in a few cases this is not so, and when it arises it is an emergency. This is the crisis that is so difficult for the relatives and for the general practitioner. To them the emergency is just as acute as any other emergency, but the process of getting the patient admittd is extremely difficult. This difficulty could be removed if the case of the long stay patient were taken out of the hospital and placed in a Social Service Unit, as earlier described. If this were done then there would be no area of caring for the elderly that would present difficulty.

The one day audit gives a picture of the care needed to be given for this group of patients. It is of interest that there were only eight long stay patients out of a group of 1,043, and this can be attributed to the effective and important role of the practice team in looking after such large numbers in their homes helped by the various elements of the community services. The figures of long stay patients would be higher if all these in this category were transferred from the welfare homes to hospital but the staff of these homes get very attached to the residents, are reluctant to agree to transfer, and cope very well indeed.

The place of a geriatric assessment unit has often been discussed, but with the setting up of the practice team and selective health visiting of the elderly, these patients are being continuously assessed and their needs planned. If doubt arises then assessment of the patients' needs should take place, preferably in the home with the geriatrician, general practitioner, health visitor, and the social worker all taking part.

The restructuring of the Health and Social Services has improved the delivery of care for the elderly because it has brought all elements under one organisational unit so that the needs of a community are assessed as a whole and solutions provided in terms of institutions and community services. General practitioners should develop and provide preventive geriatric care for their patients as a major contribution to keeping the geriatric patients at home, but the greatest problem facing family doctors today is finding accommodation for long stay patients when it is needed. The care of the elderly in all its facets is a most interesting and rewarding clinical interest, and the general practitioner team has a major role to play in it.

I wish to thank my partners, health visitors, district nurses, social worker and the staff in the various hospitals and institutions for so willingly helping me to conduct the one day audit.

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